MDR: M4-02-1919-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for date of service 8-31-01.
   b. The request was received on 1-30-02.

II. EXHIBITS

1. Requestor, Exhibit I:.
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. Response to a Request for Dispute Resolution
   b. Exhibits 1 & 2
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 6-28-02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 7-1-02. The response from the insurance carrier was received in the Division on 7-11-02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 12-27-01.

   "The explanation of benefits states that the documentation does not support the service billed…The CPT code of 99214 is an office or other outpatient visit for the evaluation and management of an established patient…I have enclosed a copy of the daily notes report by Dr. …. as well as other information for you to review to help resolve this matter."

2. Respondent: Letter dated 7-11-02:

"It is the carrier's position that a detailed examination, history, and medical decision making of moderate complexity is not documented based on the documentation provided to the carrier with the bill."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 8-31-01.

2. The Carrier has denied the disputed service as reflected on the EOB as, "F COD1 – T,N, - DOCUMENTATION DOES NOT SUPPORT THE SERVICE BILLED. CARRIERS MAY NOT REIMBURSE THE SERVICE AT ANOTHER BILLING CODE'S VALUE PER RULE 133.301 (B). A REVISED CPT CODE OR DOCUMENTATION TO SUPPORT THE SERVICE MAY BE SUBMITTED."

   Reaudit dated 1-2-02 – "Reimbursement is denied for the service billed as the documentation submitted does not support the specific level of service billed as it is defined in the 1996 TWCC Medical Fee Guideline. Rule 133.301 prohibits carriers from reimbursing a service at another billing code's value therefore no reimbursement can be recommended for the service billed in comparison with the documentation. Please submit a revised CPT code or any additional documentation which may support the service billed."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
8-31-01	99214	$71.00	$-0-	F – COD1, T, N	$71.00	Lower Extremity Treatment Guideline 134.1003 (e) (2); MFG: Evaluation/Management Ground Rules; (VI) (B). CPT Descriptor	The carrier has denied the charge in dispute as "F-COD1, T, N". CPT Code 99214 is defined as, "Office or other outpatient visit for the evaluation and a management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family." Evaluation and management of the patient is pursuant to post tertiary treatment options and allowable pursuant to the treatment guideline. However, documentation does not support the level of service billed. Therefore, no reimbursement is recommended.
Totals		$71.00	$-0-				The Requestor **is not** entitled to reimbursement

The above Findings and Decision are hereby issued this 10th day of September 2002.

Lesa Lenart, RN
Medical Dispute Resolution Officer
Medical Review Division

LL/ll